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STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

RICA LEWIS-PAYTON
EXECUTIVE DIRECTOR

October 30,2000

Mr. Mike Fiore, Acting Director
Health Care Financing Administration
Center for Medicaid and State Operations
Family and Children's Health Programs Group
Division of Integrated Health Systems
7500 Security Blvd.
Baltimore, MD 21444-1850

Dear Mr. Fiore:

I am pleased to provide the Health Care Financing Administration an original and five copies of Mississippi's request for a Research and Demonstration Waiver under Section 1115 of the Social Security Act. The waiver is a collaborative effort between the Division of Medicaid and the Mississippi State Department of Health.

The purpose of the waiver request is to allow the State of Mississippi to extend Medicaid eligibility for family planning services to all women of childbearing age with incomes at or below 185% of the federal poverty level who would not otherwise qualify for Medicaid. Women who are served in this waiver will be able to secure all family planning services offered through the Mississippi Medicaid program. Care coordination will be available to augment the direct services available through the waiver.

Weaknesses in the current system of delivering family planning services contribute to the high number of unintended pregnancies. Because this waiver addresses those weaknesses, we anticipate it will have the effect of reducing the state's unintended pregnancy rate and improving birth outcomes,

The State looks forward to utilizing these much needed services that will be made available through this waiver. Mr. Bo Bowen is the contact for this project and he can be reached at (601) 359-6134.

Sincerely,

/s/

Rica Lewis-Payton
Executive Director

cc: F.E. Thompson, Jr., M.D.

Suite 801, Robert E. Lee Building, 239 North Lamar Street, Jackson, MS 39201-1399, (601) 359-6050

MISSISSIPPI
FAMILY PLANNING WAIVER REQUEST

1115 (a) DEMONSTRATION WAIVER APPLICATION

A PROPOSAL TO REDUCE UNINTENDED PREGNANCIES
AND IMPROVE THE WELL BEING OF CHILDREN AND
FAMILIES IN MISSISSIPPI

OCTOBER 2000

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EXECUTIVE SUMMARY

The Institute of Medicine's report, "The Best Intentions, Unintended Pregnancy and the Well-Being of Children and Families," calls for a new social norm: "All pregnancies should be intended - that is, they should be consciously and clearly desired at the time of conception. Family planning services are necessary for reducing unintended or inadequately spaced pregnancies. Contraception is the cornerstone in the prevention of unintended pregnancy. (AJPH, 1995, p 479).

The State of Mississippi is requesting a Section 1115 (a) Research and Demonstration Waiver to extend Medicaid eligibility for family planning services to all women of childbearing age–with incomes at or below 185% of the federal poverty level. Current Medicaid regulation provides coverage to pregnant women and infants (less than 1 year) at or below 185% of the federal poverty level. These women are only eligible for Medicaid benefits following the confirmation of pregnancy and through a period of 60 days postpartum. After 60 days, women who no longer meet the state's more stringent financial criteria for participation in the Medicaid program lose eligibility for all benefits, including family planning. It has been estimated that more than one half of the women eligible for Medicaid in 1999 due to pregnancy (22,116) lost their Medicaid coverage after 60 days postpartum, leaving them without family planning or preventive health services coverage. Mississippi projects that providing family planning services to Mississippi women at or below 185 percent of poverty will cost the state and federal governments less than the cost of prenatal care, delivery and infant health care,

Women served through the extended eligibility will be able to take advantage of all family planning services that are offered through the Division of Medicaid and will be able to receive these services directly through any qualified provider. Direct services will be augmented with care coordination and tracking for "high risk" and "at risk" women to ensure compliance with the woman's chosen method. As further explained in the following narrative, even though these services may now be available, the services are not widely utilized, nor are they consistently followed. The availability of care coordination services will allow for enhanced education on appropriate use of chosen methods and further assurance of correct and continued usage.

The expansion of Medicaid eligibility combined with availability of care coordination services is a natural progression of the State's current family planning initiatives. It is anticipated that as a result of the Family Planning Waiver, Title X dollars can then be used for women currently not receiving services and not eligible for Medicaid.

The waiver is a collaborative effort between the Mississippi Division of Medicaid, the Mississippi Department of Human Services (DHS), and the Mississippi State Department of Health (MSDH). Both entities are committed to improving the health status of Mississippi.

The primary goal of the waiver will be to reduce unintended pregnancies in the project population and thereby reduce, by a significant degree, the number of births in Mississippi paid for by Medicaid. The Medicaid family planning 1115 (a) project is designed to improve access to family planning services by expanding Medicaid eligibility for family planning benefits and allowing the state to expand outreach and education services. As a result of the family planning project, the MSDH family planning program in Mississippi, funded by Title X, Title XX, Title V, and state funds will be able to better serve the population in need of family planning services through increased outreach, education, and care coordination services.

ERS REOUESTED

Mississippi is requesting waiver of the following sections of the Social Security Act:

Section 1902(a)(1) of the Social Security Act requires that the Medicaid State Plan be in effect for all services and all eligible recipients in all geographic areas of the state. Waiver of this section is requested to allow operation of the program in all counties of the state.

Section 1902(a) (10) (b) of the Social Security Act requires that the amount, scope and duration of services be equally available to all recipients within an eligibility category and also be equally available to categorically eligible beneficiaries.

Section 1902(e)(5) and (6) of the Social Security Act limits the eligibility of poverty level postpartum women to the 60-day period following the pregnancy. Waiver of this section is requested to extend family planning benefits to women of childbearing age whose family income is up to and including 185% of poverty level. Additionally, the state requests that family planning benefits for nonpregnant women be available through the waiver to all women who are not categorically eligible for Medicaid whose income does not exceed 185% of poverty.

Section 1902(a)(**17**) necessitates that espousal income be taken into account, and that standards be comparable for all groups. This waiver will allow all women of childbearing age who have a child or children eligible for poverty-level Medicaid to become automatically eligible for family planning benefits. In some instances the income of the spouses of these women is not counted for the children due to restrictions on step-parent deeming, where there is a step-parent involved. The intent is to disregard any excess income in order to automatically certify women in families with children eligible for poverty level Medicaid.

Mississippi requests that the Department of Health and Human Services (DHHS) grant any other waiver that DHHS deems necessary to implement the family planning waiver services for women of childbearing age who meet the eligibility requirements described in this waiver application.

***GOALS* AND OBJECTIVES**

Primary Goal

The primary goal of the waiver will be to reduce pregnancy and birth rates within the low-income population of the state (defined as women of childbearing age with family incomes at or below 185% of the federal poverty level) by reducing the rate of unintended pregnancies. This can be accomplished by improving the service delivery system and outreach. Improvement in the effectiveness of the family planning service delivery system will be accomplished by making more women eligible, providing a vehicle for outreach and client care coordination, and improving the content or scope, of family planning services.

Objectives

The primary objective will be to decrease the number of unintended births, thereby reducing the associated Medicaid costs. While these women do not qualify for Medicaid for family planning services, once pregnant, Medicaid eligibility is granted. Medicaid not only pays for prenatal and delivery costs, but also covers the first year of medical care costs for infants as well as costs for subsequent years while the patient remains eligible. Mississippi provides 12 months guaranteed eligibility for children. The average annual Medicaid family planning expenditure per recipient was $242.55 in 1999, while newborn and first year infant care cost the Medicaid program an average of $1,888 per birth. The average expenditure for the mother's care per delivery was $3,091, bringing the total average expense of a Medicaid paid birth to $4,979 in 1999. This amount does not include other assistance programs such as Food Stamps, WIC, and/or TANF payments.

The family planning expansion project will seek to address these issues through the following objectives:

1. Reduce the rate of unintended pregnancies among Mississippi women in general and among women who are eligible for Medicaid paid deliveries.

2. Improve access to high quality family planning services for women in general and among women who are eligible for Medicaid paid deliveries.

3. Decrease Medicaid costs as a result of unintended pregnancies.

4. Reduce the teen pregnancy rate.

5. Reduce the number of second births among teens.

6. Utilize care coordination services to assist women with choosing a family planning method and as a means for consistently using the method.

7. Reduce the proportion of births spaced less than two years apart in the general population among women who are eligible for Medicaid paid deliveries.

8. Reduce the number of babies born with low birth weight through outreach and education to women.

9. Increase the number of Mississippi women and teens receiving publicly funded (Medicaid, Title X, and Title XX programs) family planning services.

Decreases in prenatal, birth, newborn, and infant care expenditures during the demonstration period are anticipated to outweigh the expenditures for providing family planning benefits to this expanded target population.

The number of people estimated to be financially eligible for family planning benefits at 185% of the federal poverty level and in need of subsidized family planning services is 91,620 women 20 to 44 and 70,390 teens at 185% of federal poverty level (according to AGI).

The State of Mississippi strongly feels that expansion of family planning services to increased eligibles is a cost effective and efficient use of State and Federal Medicaid funds. The state proposes to begin the project January 1,2001, and continue the project for five years ending December 31,2005. The implementation of this project will offer family planning benefits to an expanded population of approximately 69,785 women per year.

B CKGROUND

Mississippi ranks 50th when compared to other states in both per capita and median family income. According to the 1990 United States Population and Housing Census, per capita income in Mississippi was $9,648, compared to a national average of $14,420. Median family income for a family of four stood at $24,448, more than $10,700 less than the United States average of $35,225. The overall poverty rate for Mississippi is 25.2 percent. Poverty also varies by family structure. Among families headed by married couples, the poverty rate is 17.1 percent; among those headed by a male, 42.5 percent; and among those headed by a female, 69.7 percent. The Urban Institute projects an increase in child poverty due to new welfare laws, from 9.7 million under prior law to 10.85 million under the new welfare laws. Another effect of the changes in the welfare law will be an increased poverty gap between poor families' incomes and poverty line, from 16.6 billion to 20.7 billion. Under prior law many people were eligible for Medicaid because they received Aid to Families with Dependent Children (AFDC). For some, alternative routes to Medicaid do not exist. Medicaid eligibility is not linked to the new Temporary Assistance to Needy Families (TANF).

Mississippi's 1998 fertility rate was 68.2 per 1,000 female population 15-44 years old (Mississippi Vital Statistics 1998). The pregnancy rate for adolescents ages 15-19 in

1998 was 83.7 per 1,000 adolescents, with births to teenage mothers in 1998 at 20 percent of total births. According to the Institute of Medicine's report, *The Best **Intentions,*** 57% of pregnancies in the United States are unintended. Unintended pregnancy is a major problem in the United States that cuts across racial, ethnic, socioeconomic, and demographic lines. By helping women to time and space their pregnancies, contraceptive use helps avoid the adverse health, social, and economic consequences associated with unintended pregnancies. Unintended pregnancies result in 1.6 million abortions annually (Alan Guttmacher Institute, 1997).

For many women, an unintended pregnancy is difficult, because it occurs when the woman is too young to be a parent or is unmarried, too soon after her previous birth or after she has achieved her desired family size. In FY 1998, 35,251 of the births in the state were to mothers covered by the Medicaid program (data provided by the Division of Medicaid). By definition these women had incomes under 185% of the federal poverty level, and thus constitute a significant part of the target population for this program. These women are of particular concern because they are only temporarily eligible for Medicaid due to their pregnancy status and the majority loses their eligibility after the postpartum period. **As** a consequence these women are at risk for additional closely spaced, unintended pregnancies and may fail to maintain good health practices, which could promote better birth outcomes in the future.

If unintended pregnancies were reduced through increased access **to** and utilization of family planning services, low birth weight as a factor contributing to infant mortality would also be reduced. Of particular concern in the case of low birth weight in Mississippi is the white-nonwhite gap. Just as in the case of low birth weight, there is wide disparity between the nonwhite infant mortality rate and that of white infants, with the nonwhite rate over 60 percent higher. Low income women of color are at the highest risk of unintended pregnancy. In the United States, 79 percent of pregnancies among black women are unintended, compared with 63 percent among Hispanic women and 54 percent among white women. "The greater prevalence of unplanned pregnancy among low income women and among black or Hispanic women reflects their lower levels of contraceptive use and higher likelihood of contraceptive failure" (Forrest, J.D., et al., 1996, p. 246).

The implication of welfare reform for women and children is that it is more difficult to enroll people in Medicaid if they are outside the welfare system. Fewer people will be connected to the welfare system. More parents will be working in low-wage jobs. People will be cut off due to time limits and sanctions. It will also be more difficult even for those who are on welfare to receive Medicaid.

In 1999, 20 % of the Mississippi population was certified as Medicaid eligible.

Welfare dependency is a common outcome of unintended pregnancy. **A** pregnancy's disruption of schooling can have long-term effects on the mother's ability to earn a living. Each year 175,000 women under the age of 17 give birth in the United States. **As** a result

more than 80% of these young mothers end up in poverty and reliant on welfare (Robin Hood Foundation, 1996, p. 1).

In this country, contraceptive supplies and services are expensive and women must rely on fragmented systems and programs to help them cover these costs. The intention of this waiver is to put in place a system by which women in Mississippi can more easily access family planning services in the hopes that this will reduce the number of inadequately spaced pregnancies. This, in turn, should lead to reductions in the number of adverse pregnancy outcomes and lead to a net saving in Medicaid spending.

If women are fully supported in meeting their health care needs, they will be in a better position to exercise wisely their right to make choices regarding the spacing and number of their children and to increase the interval between pregnancies.

PROJECT ADMINISTRATION

The Medicaid program is administered by the Mississippi Division of Medicaid (organization chart in Appendix A).

The Mississippi State Department of Health is the state Title X Family Planning grant recipient. The Department is charged with protecting and improving the health of Mississippi citizens. The Department of Health is organized into five offices (organization chart in Appendix B).

The design of the expansion project is built upon strong community partnerships and collaboration at all levels of government. It requires a concerted effort between the two state agencies listed above and also federal agencies, including the Office of Population Affairs and the Health Care Finance Administration.

The design blends Title XIX and Title X approaches to providing publicly funded family planning services and builds on existing administrative and service delivery systems. The project design will be developed by a work group of representatives from local health departments, MSDH central office staff, DHS, and the Division of Medicaid staff.

The expansion project will be managed by the MSDH in conjunction with the Division of Medicaid. The mission is to reduce unintended pregnancies in the project population and thereby reduce, by a significant degree, the number of births in Mississippi paid for by Medicaid.

TITLE X FAMILY PLANNING SERVICES

In Fiscal Year 1999, the MSDH received $3.5 million from Title X. The majority of the funds went to provide direct clinical services, medical supplies and education outreach. Title X family planning services were provided to 96,751 people during Calendar Year 1999. 82.5% of these were at or below 100% of poverty; 11.8% at or below 150% of

poverty; and an additional 4.4% at or below 200% of poverty.

Most family planning services for low income families are provided by the MSDH through its 105 service sites. Analysis of Title X program costs indicates that services are provided in a cost efficient manner. However, the current level of Title X funding is inadequate to serve all people in need.

Medicaid funding for the MSDH patients will complement Title X funds and enable family planning clinics to address serving a larger number of people. The proposed project will allow identification of any barriers to care and targeting of activities at the community level to address these barriers. **A** barrier limiting the availability of higher cost, but more effective, contraceptive choices will be addressed. Specifically, Depo Provera injections are a very popular and effective contraceptive method. Unfortunately, these injections are relatively expensive.

Coordination of prenatal and postpartum care, counseling and referral will also be critical program elements. The availability of a full range of current birth control methods, including recently approved methods, will allow people to choose the method most appropriate for them. This will be implemented through a primary care case management system for family planning which focuses on the care being provided by the MSDH, except in emergency circumstances.

WOMEN IN NEED

Women in need of subsidized family planning services are the number of women ages 13-44 who live in homes with an income less than or equal to 185% of poverty. 162,010 women in Mississippi are in need of subsidized/organized family planning services. In Calendar Year 1999, 96,751 females have been served in the Title X program, 59.7% of the population in need. Projecting that the service delivery system will remain constant, or increase somewhat, the Title X service delivery will fall short of meeting the needs of 65,259 women.

The proposed project will enhance the state's ability to serve these women by increasing the number of clients served with Medicaid funds, thus complementing Titles V, XX, X, and state funds.

Of the 96,751 females served in the Title X program in Calendar Year 1999, more than 80 percent are estimated to have been eligible for Medicaid if they had become pregnant. Currently, 20 percent of the Mississippi State Department of Health family planning patients are eligible for Medicaid reimbursement. This leaves a significant number of clients to obtain family planning services through the Title X system and/or other Medicaid certified providers.

Low income women are at a higher **risk** of unintended pregnancy than the national average. 74% of pregnancies to women with a family income of less than 150% of the

federal poverty level are unplanned (Forrest, J.D. et al., 1996, p. 246). Teens have a particularly high rate of unintended pregnancy. Nationally more than 80% of teen pregnancies are unintended.

TARGET POPULATION

In order to reduce the level of unmet family planning needs of Mississippi clients, reduce inadequately spaced pregnancies, and control Medicaid costs, this project will take a multi-faceted approach.

This project will extend Medicaid coverage for family planning services to clients throughout Mississippi who:

1. Have family incomes at or below 185% of the federal poverty guidelines; and

2. Are of childbearing age.

Women of childbearing age represent the primary population to be served. Women who fall outside Medicaid eligibility who are at risk for unintended pregnancies will also be allowed to participate in family planning through utilization of Title **V** or Title X funding.

Participation in the project will be voluntary for those in the target population.

ELIGIBILITY AND DURATION

Eligibility for Medicaid is determined by the Division of Medicaid which contracts out services to the Mississippi State Department of Human Services (DHS). The DHS case workers now send a notice of termination to persons scheduled to lose Medicaid or AFDC eligibility. If a member of the target population is not eligible for full Medicaid coverage through another category, she will continue to be eligible for Medicaid coverage of family planning services through this project. The DHS case workers will close the mother's categorical Medicaid coverage and notify her that she will continue to be eligible only for family planning services. It will be the responsibility of the DHS case workers to inform these women of the available family planning services and provide them with a full description of these services before or after delivery. In addition, information regarding this project will be placed in all DHS correspondence available to all Medicaid recipients. Providers will also be furnished with brochures explaining the additional benefit and asked to explain the service availability during the initial postpartum visit. The MSDH will use family planning outreach to encourage participation and coordinate where necessary.

Women who have not been certified as Medicaid eligible may apply for the family planning services at their local DHS offices or local health departments, using the current applicant short form for pregnant women as the application. The applicant's declaration of income with verification must be attached. There is no resource limit. The income

standard will be 185% of the federal poverty level for the appropriate number of persons in the household. The appropriate number of persons in the household will include parents, spouse, and children under 21 years of age.

Current estimates indicate that 55% of pregnancies to poor women are unintended, and that almost 54% of second deliveries occur within 2.5 years of the last delivery. (ASTHO, 1992). Two years is the generally recommended minimum interval between pregnancies. It will be presumed that women remain eligible for family planning services once the initial determination of eligibility has been made. Clients certified for the project will remain eligible for one year, or for the duration of the project if less than a year, without re-evaluation or change reporting requirements. Re-certification will be performed at the end of the year's eligibility. Loss of eligibility will occur only when a woman moves from the state, loose Medicaid eligibility, requests closure, or upon death.

Medicaid methodology used to determine eligibility for poverty level pregnant women and infants will be used to determine eligibility of participants in the expansion project. Enrollment in the project will take place continuously throughout the duration of the project. The MSDH considers this a cost-effective measure, because the purpose of this project is to prevent or delay pregnancy.

SERVICES

Family planning services are a major preventive strategy for reducing unintended and/or inadequately spaced pregnancies. Currently these services include medically necessary services and supplies related to birth control and pregnancy prevention services prescribed and furnished by physicians, hospitals, clinics, pharmacies and other Medicaid providers. Upon the expansion of Medicaid eligibility, a brochure which outlines the covered family planning services will be available at local public services offices. Providers will be informed of the availability of these services through a Medicaid bulletin explaining the services available and the population which has been targeted for receiving them.

Abortion services are not included as family planning services in the Mississippi Medicaid State Plan.

A protocol of care for services provided is included in Appendix C. Basic services currently provided through the preventive family planning services element include medical exams, counseling services, patient education, necessary laboratory tests, and methods of contraception. Services will generally be provided at initial exam visits, annual exam visits, follow-up visits and pregnancy test visits.

In addition to clinic based client services, the Title X program provides enhanced family planning services. These services are delivered to clients who require additional education, counseling, follow-up or outreach in order to continue to use family planning services or to access family planning services. Extended face to face counseling in the

clinic, telephone calls, or home visits are required to deliver these services.

MSDH expects the proposed project to serve some women who are not currently receiving family planning services, in some cases because they are not well informed about the risks of poorly spaced pregnancies, and in some cases because their financial condition limits their access to health services. In addition, it is anticipated that some clients of the Title X program will become eligible for Medicaid supported services under the provisions of the proposed project.

OUTREACH/CARE COORDINATION/CONFIDENTIALITY

Outreach activities to improve access to family planning services will be coordinated by the MSDH. A broad range of outreach and education strategies are proposed that will be culturally, socioeconomically and educationally appropriate to promote and ensure the effective utilization of family planning services through the expansion project. The purposes of these strategies will not only be to inform women of childbearing age about the availability of services and the services offered, but also to make them aware of the importance of family planning and the use of contraceptives.

Outreach activities will be implemented through statewide approaches and through community-based partnerships described below. The MSDH has the infrastructure in the counties to conduct needs assessments and local health planning. Also, with the county staff shifting to community-based activities, an ideal forum to conduct outreach regarding family planning already exists at the local level. Outreach tools to be developed for informing the target population will include flyers, posters, fact sheets, news releases and audio/video tapes that will be scripted using consistent messages. A Family Planning Program presentation will also be developed for local health department staff to use when soliciting local community partnerships. The work group which consist of representatives from local health departments, MSDH central office, DHS, and the Division of Medicaid will have oversight authority and approval of all outreach activities.

In addition to enhanced outreach efforts to increase the number of clients served, outreach services will also provide care coordination to women served at risk of not effectively using family planning methods. Financial access, while a factor, is certainly not the only limitation to utilization of family planning services. The proposed demonstration project will not only directly address the financial issues, but will allow Title X funds to be used to determine other barriers to care. These barriers will be addressed at the community and client level by care coordinators. Surveys of clients missing appointments will serve as the basis for identifying local barriers to care.

Other efforts to improve patient compliance will include telephone, mail and home visit contact. The goal of these efforts will be maintenance of clients in a reproductive health system of care. Appointment reminders, follow-up of missed appointments and monitoring compliance with referrals will be included in this care coordination approach.

Confidentiality will be protected by adhering to regulations contained in 42CFR 431.300-431.307. Individuals eligible under the family planning expansion project will have the same confidentiality protections as current Medicaid eligibles. Parental consent for minors will not be required, in keeping with state and federal regulations.

MULTI-FACETED MEDIA CAMPAIGN

The media campaign will be conducted throughout the state. The campaign will provide information to the target population regarding the availability of family planning services through the expansion project, the services offered, and the application process for services. This will be accomplished through broadcast and newspaper coverage to include press conferences with press kits, press releases, radio and television PSAs, direct mail promotion, telephone hotline, community outreach partners, Website, and newsletters.

The campaign will also encourage a broad range of health professionals to promote planning for pregnancy and birth control. According to a 1992 primary care providers' survey, only 36% of family physicians routinely provide family planning counseling **(U.S.** Department of Health and Human Services, 1995, p. 49).

The four goals of the campaign are: 1) improve knowledge, 2) increase access to contraceptives, 3) address the motivations/attitudes involved in contraception usage and, 4) evaluate local programs and stimulate research. The specific message and approach of the five year initiative will be determined after consulting with focus groups which will include both the consumer and provider communities.

QUALITY ASSURANCE

Services provided under the waiver, with the exception of care coordination, are currently provided as a fee-for-service program for Medicaid beneficiaries. However, a more structured quality improvement plan will be implemented with this program that mirrors those provided in managed care settings. The quality assurance component of the project has four goals:

1. To assure that family planning services are accessible to eligible clients.

2. To assure that client risk assessments include a psycho social assessment and case plan, which is appropriate for the risk level.

3. To assure that the content of family planning encounters provided through enrolled family planning providers follows the guidelines in the Medicaid Family Planning Provider Manual, and private providers that provide a family planning service follow nationally accepted recommendations as embodied in Guidelines for Women's Health Care, The American College of Obstetrics and Gynecology, 1996.

4. To ensure that an effective provider and beneficiary complaint and grievance system is in place.

Goal One

The Division of Medicaid will collect data to measure compliance with goal 1 via Medicaid claims data and a summary report from family planning providers. Baseline data for the measures will be collected before the demonstration project begins in order to establish baseline measures. Data items to be measured and methodology for measurement include the following:

- Number of family planning providers seeing patients.
- The number of enrolled Family Planning Clinic providers will be retrieved from Medicaid's provider file.
- The number of private physicians will be identified using one-year claims data to identify providers of family planning services who are not enrolled as Family Planning providers, but the service is for family planning.
- The number of providers will be monitored over time.
- Number of hours open.
- Surveys will be conducted to determine clinic hours.
- Average waiting time for a family planning appointment.
- Surveys will be conducted to determine the average waiting time for an initial, follow-up and problem visit for care provided in a clinic and appointment times for other providers. This will be measured via complaints.
- Number of new clients enrolled for the demonstration.
- New awards will be identified monthly, by county, and traced over time, and compared, as a ratio, to number of providers.
- Number of overall clients receiving family planning services through the demonstration or regular Medicaid.
- Baseline data will be extracted to determine the number of family planning clients. This will be compared to future years to determine if there was an increase in the number of clients receiving care through the demonstration and through regular Medicaid for family planning services.

Goal Two

The Division of Medicaid will collect data to measure goal two via quality assurance audits of care coordination records of a statistically valid number of enrolled family planning providers.

- Providers selected for review will be determined through random selection. In order to be eligible for review, the provider must have seen a minimum of twenty five beneficiaries during the past year.
- Ten percent of the provider's cases will be selected for review with a maximum of 35 records reviewed.
- Records will be reviewed for documentation of the risk assessment screening that includes bio-psychosocial assessment and case planning. Providers will have standardized care coordination forms that include the screening tool and case

planning form. 90% of cases reviewed must have appropriate documentation.

- If performance is less than 90%, the provider must submit a corrective action plan.
- Providers who are required to submit corrective action plans will have follow-up reviews done approximately **6** months after the review that reflects a deficiency.

Goal Three

To measure compliance with goal 3, medical records from enrolled Family Planning providers will be reviewed for documentation to assure that family planning clients receive the content of medical care as required in the Medicaid Family Planning Provider Manual.

- Medical records reviewed for goal **2** may also be used to measure performance for goal three.
- Clinic providers will be reviewed for compliance to visit protocols defined in the manual. 90% of the charts reviewed must be compliant with all manual guidelines.
- If performance falls below 90%, the provider must submit a corrective action plan.
- Providers who are required to submit corrective action plans will have follow-up reviews done approximately **6** months after the review that reflects a deficiency.
- All providers will be monitored through the Division of Medicaid through established procedures.

Goal Four

To measure compliance with goal **4,** the Division of Medicaid will receive complaints, orally and in writing, and will follow through resolution.

- Complaints involving quality of care will be directed to the Division of Medicaid. The complaint will be documented and include name of complainant, date complaint received, date of incident, nature of complaint and resolution. For complaints that are unable to be resolved to the satisfaction of the complainant, the formal grievance process can be initiated.
- Complaints involving access to care may be directed to the Division of Medicaid. The complaint will be documented and include name of complainant, date complaint received, date of incident, nature of complaint and resolution. For complaints that are unable to be resolved to the satisfaction of the complainant, the formal grievance process can be initiated.
- Complaints involving covered services should be directed to the Division of Medicaid. The complaint will be documented and include name of complainant, date complaint received, date of incident, nature of complaint and resolution. For complaints that are unable to be resolved to the satisfaction of the complainant, the formal grievance process can be initiated.
- All central complaint logs will be maintained and all complaints will be entered on the log. This log will be maintained at the Division of Medicaid and will be available on the LAN. This log will include, at a minimum:

  Date Received
  Complainant
  Person Receiving Complaint
  . Nature of Complaint

Resolution
Comment
Date complaint Resolved
Was grievance filed?

Formal grievances must be submitted to the Division of Medicaid.

- Grievances must be in writing.
- The time frame for resolution is ten (10) working days from the receipt of the grievance. The designated person in the Division of Medicaid will coordinate grievance activities with appropriate Agency staff and is responsible to ensure that grievances are investigated as appropriate.
- Grievances of an immediate or urgent nature (life threatening situations, perceived harm, etc.) must not exceed a forty-eight **(48)** hour review.
- Beneficiaries must be notified, in writing, of the disposition of the grievance and the ability to request a fair hearing.
- The grievance resolution at the Agency level is binding unless the beneficiary files a written appeal to the Agency for a fair hearing. At that point, the Legal Division at the Division of Medicaid will conduct the hearing through established protocols.

EVALUATION

The major components of the evaluation process for this demonstration project will consist of a series of quasi-experimental pre-post comparisons of birth rates, pregnancy spacing, utilization of family planning services, and rates of unintended pregnancy prior to and following the initiation of the family planning expansion project. In addition, the evaluation will provide information to assess the fiscal impact of the project, including information required to determine budget neutrality annually, and for the life of the project. The evaluation will be conducted under the guidance **of** a contract with the Division of Medicaid.

Data for the evaluation will come from multiple data sets including the Medicaid Management Information System (MMIS) from Mississippi's Medicaid Program, MSDH Title X Family Planning program data, birth records from the Mississippi State Department of Health Vital Statistics, and survey information. For the populations of interest, MSDH will measure: 1) the number of clients served by this project, **2)** the number of pregnancies, fertility rate, and spacing of pregnancies, **3)** the number of births and birthrate, and **4)** the types and frequency of family planning services utilized. Costs will be determined for family planning services, including prenatal care, delivery, and infant care.

The following is a list of the project objectives linked with major hypotheses and outcome measures for the evaluation of the demonstration project.

Objective 1

Reduce the rate of unintended pregnancies among Mississippi women in general and among women who are eligible for Medicaid paid deliveries.

Hypothesis 1

There will be a reduction in the rate of unintended pregnancies among Mississippi women in general and among women who are eligible for Medicaid paid deliveries following the implementation of the expansion project.

Measures

Two statewide surveys will be implemented to assess the rate of unintended pregnancies among Mississippi women. The first survey will be a representative random sample of postpartum women in Mississippi. Names and birth outcomes of postpartum women will come from birth records from the MSDH Bureau of Vital Statistics. The women surveyed will be asked questions about the intendedness of their pregnancies. The questions will be parallel to those in the CDC PRAMS, the Pregnancy Risk Assessment Monitoring System.

Knowing that postpartum surveys miss pregnant women who obtained an abortion or miscarried, a second survey will be conducted of a representative sample of women ages 15-44. It will consist of the questions in the Family Planning Issues module of the CDC Behavioral Risk Factor Surveillance System (BRFSS). These questions relate to unintended pregnancy and the use of contraception and family planning services.

For both the postpartum and BRFSS-type surveys, an analysis of the baseline data to data collected after the initiation of the expansion project will be made to determine changes in the rates of unintended pregnancies and changes in the rates of unintended pregnancies for women eligible for Medicaid paid deliveries in order to validate Medicaid savings.

Eligibility will be estimated by income and family size data that are part of the two surveys. Data from PRAMS surveys and BRFSS surveys from other states will be used to compare with Mississippi's results as a way to control for secular trends.

Objective 2

Improve access to high quality family planning services for women in general and among women who are eligible for Medicaid paid deliveries.

Hypothesis 2

There will be an increase in the annual number of persons obtaining publicly funded family planning services in Mississippi following the implementation of the expansion

project.

Measures

Medicaid will require submission of patient data by providers to determine the method of contraception used. Trend analyses will be used to compare the types of contraception women and teens use before and after the implementation of the expansion project. Title X Family Planning Program data from other states will be compared to Mississippi to control for secular trends.

Objective 3

Decrease Medicaid costs as a result of unintended pregnancies.

Hypothesis 3

The expansion project will result in a decrease in the annual number of Medicaid paid deliveries in Mississippi and a decrease in the number of Medicaid paid deliveries to teenage mothers in Mississippi.

Measures

Mississippi Medicaid will provide annual measures of the numbers and ages of women receiving Medicaid paid deliveries in Mississippi. Trend analyses will be used to compare the annual number of Medicaid deliveries during the expansion project to the annual number of Medicaid deliveries in the previous years. Separate trend analyses will be done for teenage women only.

Objective 4

Reduce the teen pregnancy rate.

Hypothesis 4a

A greater number of sexually active teens will report using a birth control method following implementation of the expansion project.

Measures

The Mississippi Youth Risk Behavior Survey (YRBS) data will be used to assess the use of birth control methods, comparing the percent of sexually active teens reporting birth control use at baseline to subsequent years once the expansion project has been implemented. Data from YRBS surveys from other states will be used to compare to Mississippi to control for secular trends.

Hypothesis 4b

There will be a reduction in the pregnancy rate following the implementation of the expansion project.

Measures

Birth and abortion records from the Mississippi State Department of Health, Bureau of Vital Statistics, will be use to compare the teen birth rate at baseline to subsequent years once the expansion project has been implemented. Mississippi is fortunate to have a long history of required abortion reporting. Since the family planning expansion project is only one of multiple strategies Mississippi will be using to reduce teenage pregnancy, it will be difficult to ascertain the impact of this project alone on the teen pregnancy rate. Teen birth data, but not abortion data, from other states can easily be obtained for comparison purposes.

Objective 5

Reduce the number of second births among teens.

Hypothesis 5

There will be a reduction in the proportion of births to teens which are their second births.

Measures

Birth records from the Mississippi State Department of Health, Bureau of Vital Statistics will be used to compare the proportion of second or more births for teens at baseline to the proportion in subsequent years. Vital statistics data from other states will be used to compare to Mississippi to control for secular trends.

Objective 6

Utilize care coordination services to assist women with choosing a family planning method and as a means for consistently using the method.

Hypothesis 6

There will be an increase in the number of women consistently utilizing the chosen family planning method.

Measures

For MSDH patients, the current system will be modified (PIMS) to show retention of clients by chosen methods in order to track clients. Follow-up will be generated for

those individuals to ensure care coordination services are acceptable.

Objective 7

Reduce the proportion of births spaced less than two years apart among women who are eligible for Medicaid paid deliveries.

Hypothesis 7

The proportion of inadequately spaced births (less than two years) in general and among women eligible for Medicaid paid deliveries will decline following the implementation of the expansion project.

Measures

Mississippi Medicaid data and birth records from the MSDH, Bureau of Vital Statistics will be used to compare the spacing of all deliveries and Medicaid deliveries for all women and teens during the expansion project to spacing in previous years. Vital statistics data from other states will be used to compare to Mississippi to control for secular trends.

Objective 8

Reduce the number of babies born with low-birth weight through outreach and education to women.

Hypothesis 8

The increase in the number of women of childbearing age receiving family planning educational opportunities will promote improved health outcomes and normal birth weights.

Measures

Mississippi Medicaid data will be used to assess the numbers of low birth weight deliveries reimbursed before and during the expansion project.

Objective 9

Increase the number of Mississippi women and teens receiving publicly funded (Medicaid and Title X program) family planning services.

Hypothesis 9a

There will be an increase in the annual number of women and teens obtaining family

planning services at Title X clinics following the implementation of the expansion project.

Measures

The current MSDH family planning data collection system, called PIMS, includes a question about payment source. The PIMS data will be used to determine the numbers and ages of women using Medicaid and Title X family planning services at our clinics. Trend analyses will be used to compare the number of women served before and during the expansion project. Title X Family Planning Program data will be available from other states for comparison purposes.

Hypothesis 9b

Among women who do not use any birth control, fewer will report not being able to pay for birth control as the reason for non-use.

Measures

Questions added to the BRFSS-type survey include current use of family planning services and reasons for not using birth control for non-users. A comparison of baseline data to data collected following the initiation of the expansion project will be used to determine changes in the prevalence of those reporting not being able to pay as the reason for not using birth control. Data from BRFSS surveys from other states using this module will be used to control for secular trends.

BUDGET NEUTRALITY

The provision of family planning services directly results in substantial savings - in both human and financial terms. According to the Alan Guttmacher Institute, if all publicly funded family planning services were no longer available, the women who rely on them would have 1.2 million additional unintended pregnancies each year (Forrest, J.D., et al., 1996, p. 188).

According to a recent analysis by the Alan Guttmacher Institute, since a large percentage of women receiving publicly funded family planning services are Medicaid recipients or would become eligible if they became pregnant, "every public dollar spent on contraception saves **$3**.00 that would otherwise have to be spent for pregnancy-related and newborn medical care alone" (Forrest, J.D., et al., 1996, p. 188). This conservative savings estimate does not account for welfare benefits and other publicly funded social services consumed by low income women and their children. When considering other public expenses like welfare and nutritional services, the average government savings is $4.40 for every $1.00 spent on family planning services (Forrest, J.D., et al., 1990, p.6).

KEY ASSUMPTIONS

According to preliminary projections, the expansion project will be budget neutral by the end of the second year. By the end of the five year demonstration project, there will be a substantial savings to both the State of Mississippi and the federal Medicaid program.

Number of Clients

The number of clients who can be served annually with current project funding is 96,751. This number represents a reasonable portion of the target population, Mississippians with incomes at or below 185% of poverty. Many clients in the target population are currently served by the Title X program. New clients are expected to increase rapidly in the first 18 months. As a result, full enrollment could be reached by the end of the second year of the project.

Cost Per Client

The cost of family planning services, including contraceptives, is estimated at an average of $200.00 per client per year based on Medicaid reimbursement levels for family planning clients in Mississippi. A 90/10 match is assumed on these expenditures.

Births Averted

A combined estimate for current clients and new clients is that 6% per year will avert an unintended birth as a result of the project. This is a reasonable goal in light of the estimated rate of unintended births in Mississippi's target population.

Savings

When a woman at 185% of poverty becomes pregnant, one person is added to the Medicaid roles. Following the birth, in most cases, a second person is added to the Medicaid roles.

Thus, all births averted by the project would result in savings to the Medicaid program. Savings per averted birth is underestimated for prenatal care, delivery, and routine medical care for the mother.

The savings would be expected to begin to accrue nine months after the start of the project, but for simplicity, all savings are shown on a one year lag period.

Additional Medicaid Savings

Although not shown in the worksheet, additional savings are expected to accrue to the Medicaid program:

- Child health care costs that would have been incurred beyond the post project year (up to 18 years of age for children under 100% poverty). Savings for young children's health care are predicted due to improved health outcomes of pregnant women and reduction of unintended pregnancies.

- Unintended births are more likely to be low birth weight and have higher medical costs, including long term costs due to disabilities.

- With Title X dollars freed up, additional clients outside the target population can be served, thus averting additional births. Some of the women would have qualified for Medicaid emergency assistance for delivery and Medicaid coverage for their children up to age 18.

- Routine health care costs for women who would have ended up on the Mississippi health care roles had they had an unintended birth.

Additional non-Medicaid federal savings are expected to accrue but have not been estimated, including WIC, TANF, food stamps, etc. Savings in terms of decreased social costs are incalculable.

Budget Neutrality Worksheet

Mississippi's budget neutrality model is laid out in worksheet form, with the worksheet showing ALL COSTS. The following narrative describes the worksheet:

ALL COSTS Worksheet

The main row headings of the ALL COSTS worksheet is WITHOUT WAIVER, WITH WAIVER, and DIFFERENCE. There is a column for each year of the project (Years 1-5). In recognition of the fact that gestation is nine months long, births are not projected to be averted nor savings accrued until at least nine months after the project begins. To simplify the presentation of this issue, a one-year lag period was used. Therefore savings for Year 1 are shown in Year **2,** savings for Year 2 are shown in Year 3, etc. This also means the savings for Year 5 are not included in the model.

WITHOUT WAIVER
Per Capita estimates for Basic Family Planning Services, Deliveries, and Infant Health Care are estimated as follows: Basic Family Planning Service, including an annual visit, contraceptives and other services as necessary, $200; delivery costs, including routine medical care, prenatal care and delivery, $3,091. Infant Health Care for one year, $1,888.

The number of deliveries and therefore infants that are covered by Medicaid each year is about 15,000. Since these costs should be the same under WITHOUT WAIVER and WITH WAIVER, they do not impact the DIFFERENCE line.

WITH WAIVER
More details on the administrative budget for the Expanded Family Planning Service will be discussed at a later time. However, it will include personnel, travel, supplies, system changes, and an evaluation component. Per capita costs are estimated at $200. The maximum number of persons that can be served annually with available Medicaid Expansion finding is **69,785.** The number of persons in Year 1 is less than in Year **2** because of the need to allow time for start-up.

Births are not expected to be averted until at least nine months after the project begins. To simplify the presentation of this issue, we conservatively used a one-year lag period. **A** reduction in deliveries and thus infant health care is therefore shown beginning in Year 2. The size of the reduction is six percent times the number of clients served in the expansion. This means that when the project is fully operational, it is estimated that 3,451 unintended births will be averted each year.

DIFFERENCE
This line is simply the subtraction of the WITH WAIVER line from the WITHOUT WAIVER line.

Budget Neutrality Worksheet for Mississippi

ALL COSTS

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
WITHOUT WAIVER						
Deliveries						
Per Capita	$ 3,091	$ 3,091	$ 3,091	$ 3,091	$ 3,091	
Persons	17,000	17,000	17,000	17,000	17,000	
Total	$ 52,547,000	$ 52,547,000	$ 52,547,000	$ 52,547,000	$ 52,547,000	$262,735,000
Infant Health Care						
Per Capita	$ 1,888	$ 1,888	$ 1,888	$ 1,888	$ 1,888	
Persons	17,000	17,000	17,000	17,000	17,000	
Total	$ 32,096,000	$ 32,096,000	$ 32,096,000	$ 32,096,000	$ 32,096,000	$160,480,000
TOTAL Without Waiver	$ 84,643,000	$ 84,643,000	$ 84,643,000	$ 84,643,000	$ 84,643,000	$423,215,000
WITH WAIVER						
Expanded FP Service						
Administration	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 500,000
Systems Changes	$ 20,000	$ 5,000	$ 5,000	$ 5,000	$ 5,000	$ 40,000
Subtotal	$ 120,000	$ 105,000	$ 105,000	$ 105,000	$ 105,000	$ 540,000
Per Capita	$ 200	$ 200	$ 200	$ 200	$ 200	
Persons	55,246	69,785	69,785	69,785	69,785	
Subtotal	$11,049,200	$13,957,000	$13,957,000	$13,957,000	$13,957,000	$66,877,200
Total	$ 11,169,200	$14,062,000	$14,062,000	$14,062,000	$14,062,000	$67,417,200
Deliveries						
Per Capita	$ 3,091	$ 3,091	$ 3,091	$ 3,091	$ 3,091	
Persons without Waiver	17,000	17,000	17,000	17,000	17,000	
Averted Births	-0-	(3,315)	(4,187)	(4,187)	(4,187)	
Total	$52,547,000	$42,300,335	$53,604,983	$53,604,983	$53,604,983	$ 213,662,284
Infant Health Care						
Per Capita	$ 1,888	$ 1,888	$ 1,888	$ 1,888	$ 1,888	
Persons without Waiver	17,000	17,000	17,000	17,000	17,000	
Averted Births	-0-	(3,315)	(4,187)	(4,187)	(4,187)	
Total	$32,096,000	$25,837,280	$24 190,944	$24,190,944	$24,190,944	$130 506 112
TOTAL With Waiver	$95,812,200	$82,199,615	$77,857,927	$ 77,857,927	$ 77,857,927	$411,585,596
DIFFERENCE	($11,169,200)	$ 2,443,385	$ 6,785,073	$ 6,785,073	$ 6,785,073	$ 11,629,404

Budget Neutrality Worksheet for Mississippi

FEDERAL COSTS

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
WITHOUT WAIVER						
Deliveries						
Per Capita (77%)	$ 2,380	$ 2,380	$ 2,380	$ 2,380	$ 2,380	
Persons	17,000	17,000	17,000	17,000	17,000	
Total	$ 40,460,000	$ 40,460,000	$ 40,460,000	$ 40,460,000	$ 40,460,000	$202 300 000
Infant Health Care						
Per Capita (77%)	$ 1,454	$ 1,454	$ 1,454	$ 1,454	$ 1,454	
Persons	17,000	17,000	17,000	17,000	17,000	
Total	$ 24,718,000	$ 24,718,000	$ 24 718 000	$ 24,718,000	$ 24,718,000	$123,590,000
TOTAL Without Waiver	$ 65,178 000	$ 65,178,000	$ 65 178,000	$ 65,178 000	$ 65 178,000	$325,890 000
WITH WAIVER						
Expanded FP Service						
Administration (50%)	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 250,000
Systems Changes (75%)	$ 15,000	$ 3,750	$ 3,750	$ 3,750	$ 3,750	$ 30,000
Subtotal	$ 65,000	$ 53,750	$ 53,750	$ 53,750	$ 53,750	$ 280,000
Per Capita (90%)	$ 180	$ 180	$ 180	$ 180	$ 180	
Persons	55,246	69,785	69,785	69,785	69,785	
Subtotal	$ 9,944,280	$12,561,300	$12,561,300	$12,561,300	$12,561,300	$60,189,480
Total	$ 10,009,280	$12,615,050	$12 615 050	$12,615,050	$12 615.050	$60,469,480
Deliveries						
Per Capita (77%)	$ 2,380	$ 2,380	$ 2,380	$ 2,380	$ 2,380	
Persons without Wavier	17,000	17,000	17,000	17,000	17,000	
Averted Births	-0-	(3,315)	(4,187)	(4,187)	(4,187)	
Total	$40.460.000	$32.570.300	$30,494,940	$30,494,940	$30,494,940	$ 164 515 120
Infant Health Care						
Per Capita (77%)	$ 1,454	$ 1,454	$ 1,454	$ 1,454	$ 1,454	
Persons without Waiver	17,000	17,000	17,000	17,000	17,000	
Averted Births	-0-	(3,315)	(4,187)	(4,187)	(4,187)	
Total	$24 718,000	$19,897,990	$18,630,102	$18,630,102	$18,630,102	$100,506,296
TOTAL With Waiver	$75 187.280	$65 083 340	$61 740,032	$ 61 740,032	$ 61,740,032	$325,430 836
DIFFERENCE	($10.002 280)	$ 2,660	$ 3,437,908	$ 3,437 308	$ 3,437 308	$ 3,3 104

Percentages in the left-hand column are the federal match rates applied to ALL COSTS to calculate FEDERAL COSTS.

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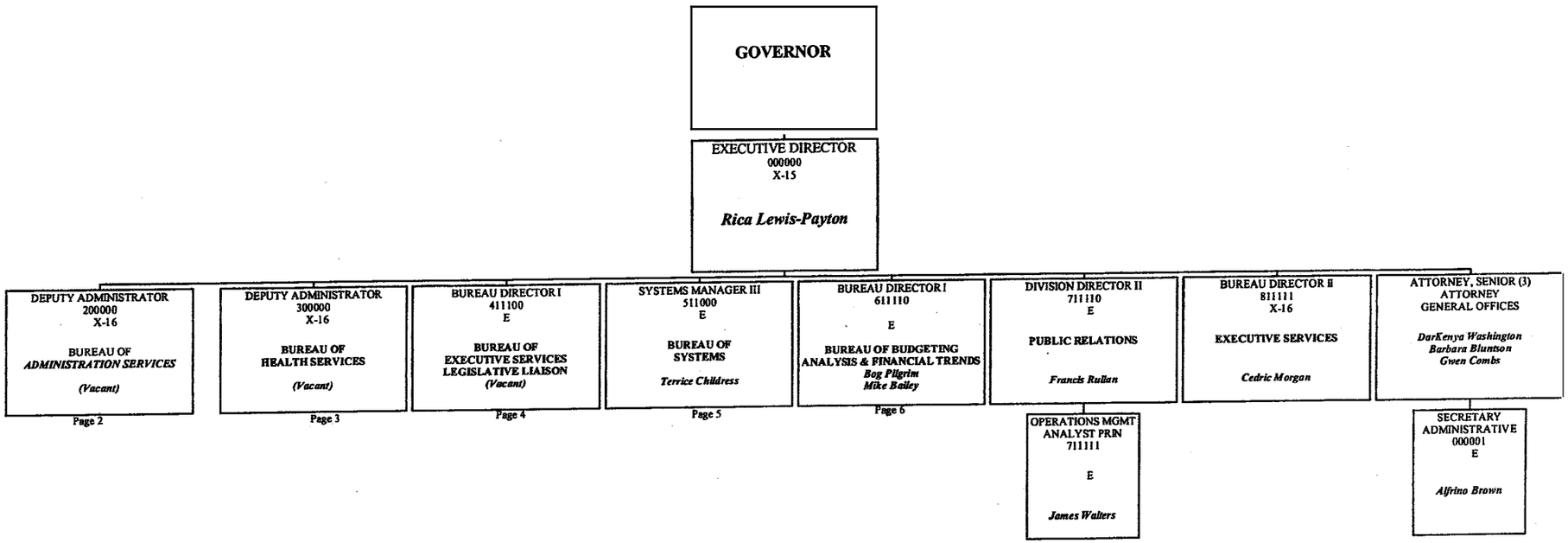
APPENDIX A

DIVISION OF MEDICAID
AGENCY NO. 0665
FY 2001
EFFECTIVE September 14, 2000

RICA LEWIS-PAYTON



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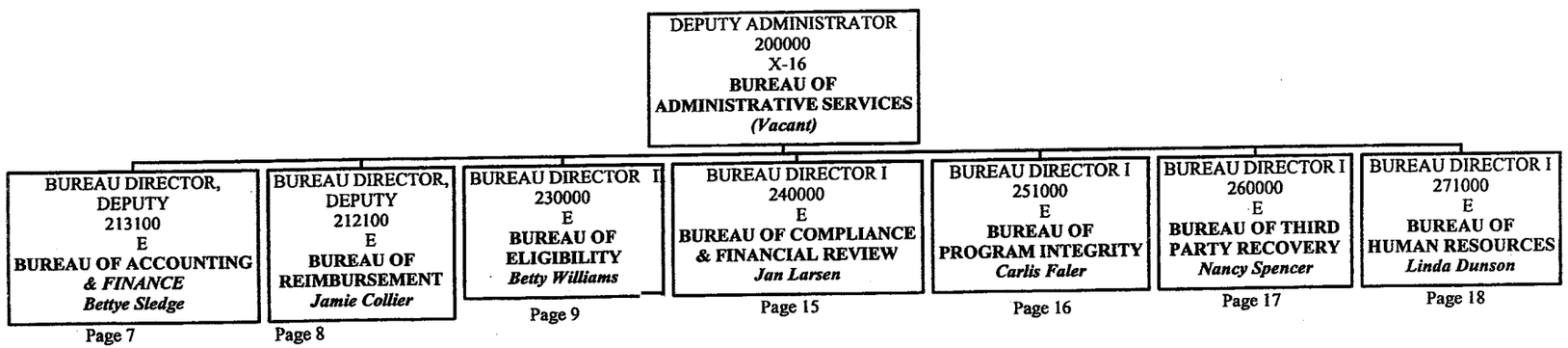
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Bettye Sledge
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Page 8
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& FINANCIAL REVIEW
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PROGRAM INTEGRITY
Carlis Faler
Page 16
BUREAU DIRECTOR I
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BUREAU OF THIRD
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HUMAN RESOURCES
Linda Dunson
Page 18

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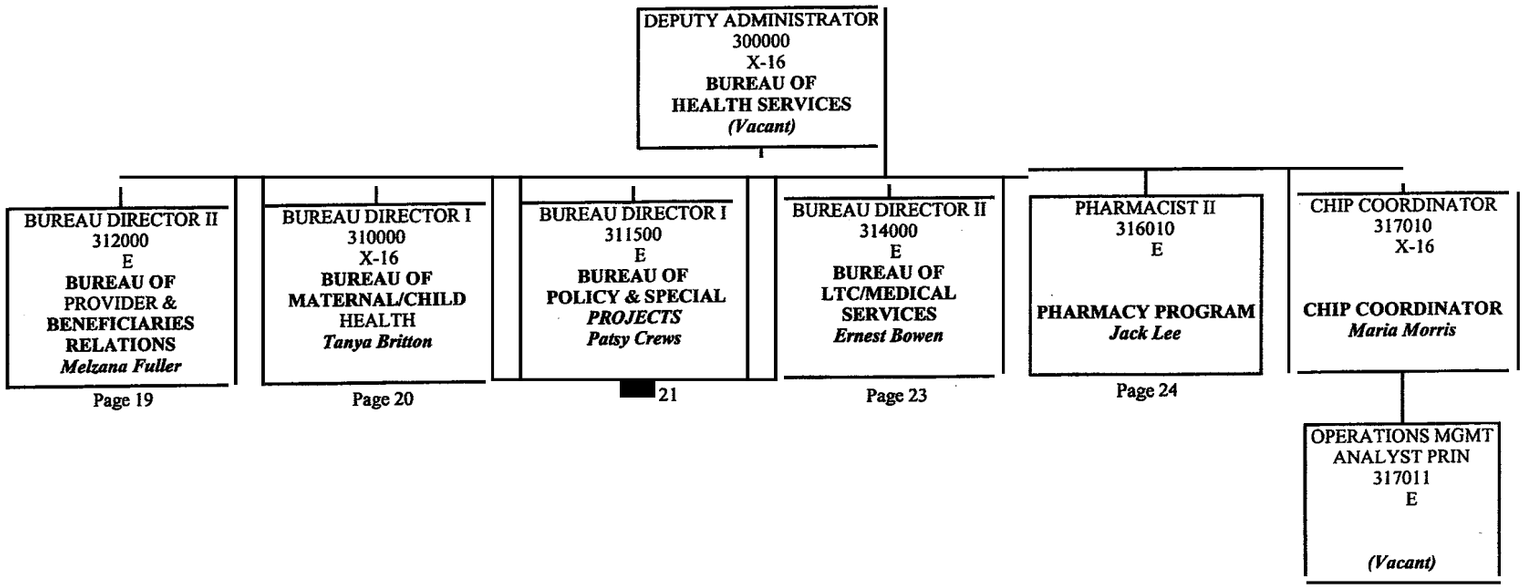
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RELATIONS
Melzana Fuller
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MATERNAL/CHILD
HEALTH
Tanya Britton
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POLICY & SPECIAL
PROJECTS
Patsy Crews
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LTC/MEDICAL
SERVICES
Ernest Bowen
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PHARMACIST II
316010
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PHARMACY PROGRAM
Jack Lee
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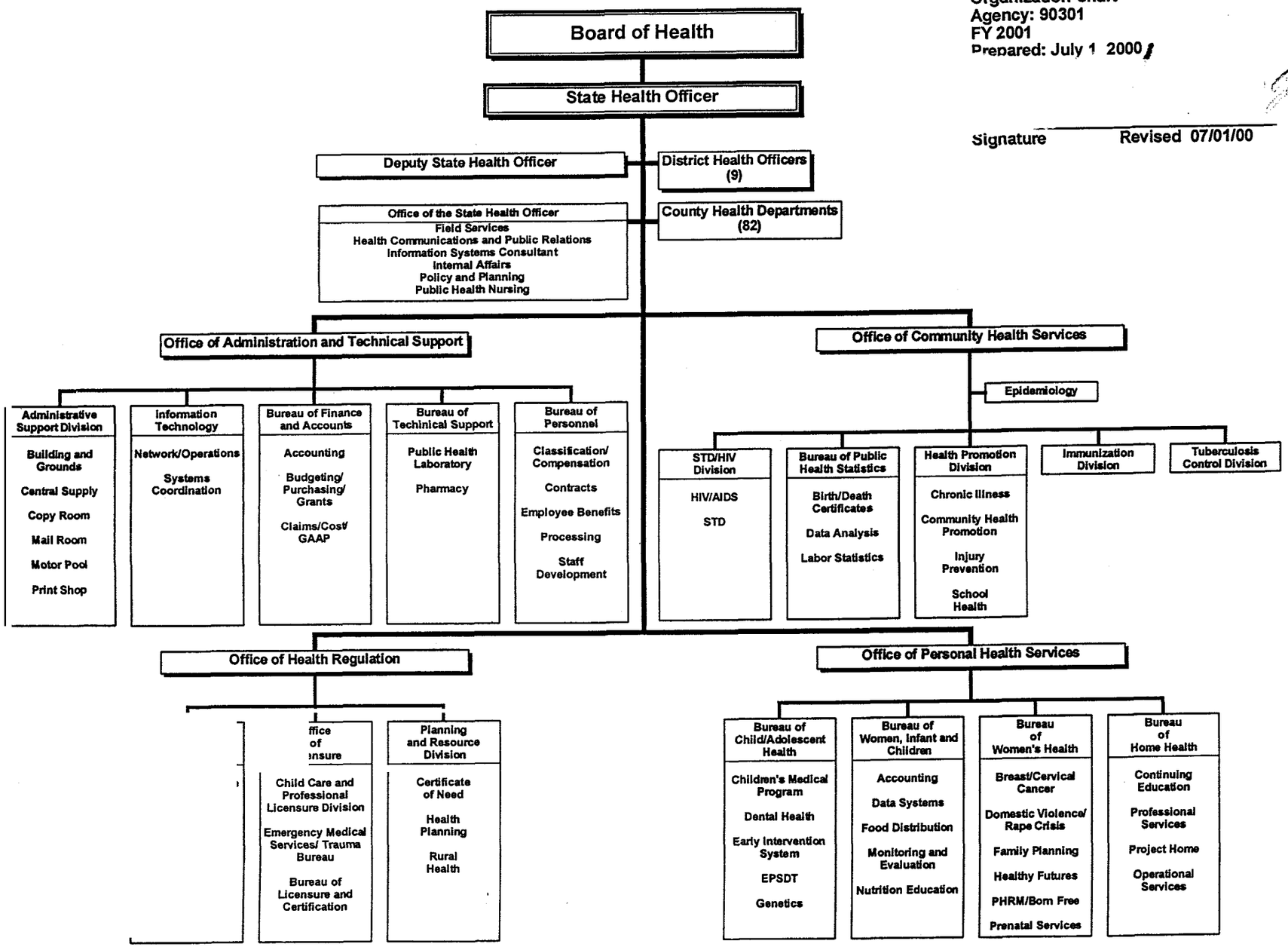
CHIP COORDINATOR
317010
X-16
CHIP COORDINATOR
Maria Morris
OPERATIONS MGMT
ANALYST PRIN
317011
E
(Vacant)

APPENDIX B

MISSISSIPPI STATE DEPARTMENT OF HEALTH

Mississippi State Department of Health
Organization Chart
Agency: 90301
FY 2001
Prepared: July 1 2000

Signature Revised 07/01/00



APPENDIX C

MANUAL FOR FAMILY PLANNING SERVICES

REPRODUCTIVE HEALTH DIVISION
BUREAU OF WOMEN'S HEALTH
OFFICE OF PERSONAL HEALTH SERVICES
MISSISSIPPI STATE DEPARTMENT OF HEALTH
Revised 3/96
Revised 6/96
Revised 9/97
Revised 3/2000

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XI. Appendices

COMPONENTS OF THE FAMILY PLANNING PROGRAM

The Mississippi State Department of Health family planning program envisions a world where every woman and man receives the health care and education to stay healthy, where every child is born wanted and healthy, and where sexuality is accepted as an integral part of every person's life.

The mission of the MSDH family planning program is to promote awareness of and ensure access to reproductive health benefits by encouraging individuals to make informed choices that provide opportunities for healthier lives.

Family planning means much more than providing contraceptive services. Family planning means providing men and women with appropriate information, services, and methods to determine the timing and spacing of their children.

The target populations are teenagers and men and women at or below 150% of poverty level. **A** fee system with a sliding scale is used. Under this scale, clients with an income at or below 100% poverty level are not charged for services. Reimbursement is sought for Medicaid eligible clients.

The family planning program provides:

* Medical and nonmedical counseling about methods of contraception,
* Medical examination and provision of contraceptives, and
* Pregnancy testing and counseling

The family planning program also provides blood pressure screening, breast/cervical cancer screening, treatment for sexually transmitted diseases, preconceptual care. sterilization, and infertility services. Access to other MSDH services such as WIC. immunizations, prenatal care, child health, and children's medical services is provided to family planning clients and their families.

The MSDH family planning program adheres to state and federal regulations. It will not use experimental drugs, does not provide abortion as a family planning method, and does not use Title **X** funds for fund raising or lobbying.

TITLE X ASSURANCE OF COMPLIANCE

- Provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents).

- Provide services without subjecting individuals to any coercion to accept services or coercion to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services.

- Provide services in a manner which protects the dignity of the individual.

- Provide services without regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status.

- Not provide abortions as a method of family planning.

- Provide that priority in the provision of services will be given to persons from low income families.

- Encourage family participation in the decision of minors to seek family planning services.

- Provide counseling to minors on how to resist coercive attempts to engage in sexual activities.

- Provide that charges will be made for services to persons other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except that charges to persons from families whose annual income exceeds 250 percent of the levels set forth in the most recent **CSA** Income Poverty Guidelines (45 **CFR** 1060.2) will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.

- Provide services without the imposition of any durational residency requirement or requirement that the patient be referred by a physician.

GUIDELINES FOR THE MISSISSIPPI STATE DEPARTMENT OF HEALTH FAMILY PLANNING PROGRAM

I. Family Planning Service Delivery

A. Appointments are made available on a priority basis to anyone needing and/or desiring services. Services are targeted to clients at or below 150% of poverty level and teens.

- Whenever possible, teens should be seen on a walk-in basis for counseling, offer of barrier method and QuickStart if indicated.

B. Appointments are scheduled at a time and place to facilitate accessibility and to encourage early and continuous contraceptive care.

C. Outreach is encouraged to get clients into care before an unplanned pregnancy occurs.

D. Clients should obtain appointments for nursing services within 7-10 days, medical service within **14** days, and STD treatment on the same day as requested. Brief counseling and spermicide/condoms should be available on the same day also.

E. Routine visits are annually and then method specific. Visits are indicated based on individual client need; the greater the need, the more frequent the visits.

F. Interdisciplinary care to include psychosocial, nutrition, nursing, medical care, and health education. Home visiting should be available on a case by case basis at all health departments. Follow-up/tracking is necessary to assure continuous care.

G. Special clinic appointments may be planned for adolescents with consideration given to their psychological, physical, educational and economic needs. Adolescents should receive appointments within 5 working days.

H. Clinic schedules should be made available to other agencies and community organizations in order to encourage client referrals.

I. Joint management includes coordination of services provided by a local private physician and the county health department. Private physician medical visit information will be acceptable for client to be enrolled into the MSDH Family Planning Program. Documentation from the private physician should include: a complete history and physical exam, results of Pap smear done within the last *6* months, lab work provided by the referring physician, and an order for the family planning method. An appointment should be scheduled to complete/update history and secure remaining lab work.

If client declines or does not return for the appointment, no follow-up is needed. Future appointments with the county health department will be given **for** resupply and annual exam as appropriate. If patient is not on Medicaid, she should be charged according to sliding fee scale.

II. Family Planning Record

A. Provides a record of medical, psychosocial, nutritional and nursing services during enrollment in the family planning program

B. Provides a method for assessing, planning, implementing, and evaluating health service and medical care

C. Must be accurate and complete

D. Every effort must be made to assure client confidentiality. No information obtained by staff about individuals receiving services may be disclosed without the individual's consent, except as required by law or as necessary to provide services.

III. Risk Assessment

Every family planning client should be assessed for health practices and problems at the initial visit and re-evaluated at each visit thereafter. Basic reproductive health services are offered at **MSDH** clinics; other providers may be used for more complex care.

IV. Counseline and Education

A. Education **of** the family planning client and his/her family is as important as physical care and may be provided by all members of the health care team.

B. Individual and/or group teaching should include:

1. Orientation to clinic services;

2. Preconceptual/Family Planning Counseling/Education

- Importance and usefulness of family planning;
- Personal health practices (hygiene, common side effects of method, exercise, safe sex);
- Anatomy and physiology of reproduction;
- Risk reduction counseling regarding avoidance of smoking, alcohol, street drugs;
- Nutrition; Folic Acid Supplements used prior to pregnancy decreases the incidence of neural tube defects;
- Other areas as indicated by individual needs.

C. When requested, alternatives (adoption, abortion, emergency contraception, foster care) should be discussed with the client. Information should be nondirective and shall include all alternatives.

VI. Follow-Up Procedures

A. Tracking

1. A mechanism that assures continuity and appropriateness of care based on MSDH protocol for all clients is utilized in every health department. Clients who are referred out **of** the health department system for specific services (i.e., medical care) are to be followed in the health department with other support services - nutrition counseling, social services, and public health nursing.

2. Missed appointments require follow-up:

a. All records of high risk clients (IUD in place, abnormal Pap, abnormal lab, STD's ,etc.) and teens should be reviewed by a public health nurse after the 1st missed appointment, to determine appropriate follow-up, based on the medical risk involved.

- Telephone contact should be utilized as a first attempt for follow-up.
- Home visits should be provided for high risk clients if other contacts have been unsuccessful.

All low risk clients should be reappointed after the 1st missed appointment. If 2nd appointment failed, consider closure.

- Telephone contact should be utilized as a first attempt for follow-up.
- Appointment reminder/notices to the home may be used.

b. Refer to Social Worker or PHN those clients who have complicated barriers to care, agree to continue care but still miss appointments, or have a high risk situation.

VII. Community Education

A. Each district is encouraged to employ a minimum of one health educator who is available to present reproductive health and educational programs on family planning services. These programs should be appropriate for schools, organizations, parent and parent-child groups, and other agencies.

B. Local health departments should post notices of services offered in the waiting areas. Educational materials on various topics should be placed in public areas. Plans should be implemented to get information to client populations at risk for unplanned pregnancy.

C. Materials used by education staff are subject to approval by the District Information and Education Review Committee.

VIII. Staff Orientation and Training

A. Each new employee shall receive orientation by their direct supervisor and the District MCH/FP Coordinator or designee. This orientation shall include a review of program philosophy and concepts of integrated care. New employee training should last until the employee can function safely at an entry level of performance.

B. Each year, a training program will be implemented by the Program Director and District staff. Content will be determined by program reviews, staff requests, and changes in medical techniques or care guidelines. National standards for safety and quality of care will be consulted. Training information will follow MSDH policies and procedures. District Staff are responsible for receiving input from county staff on training needs.

THE INITIAL/ANNUAL FAMILY PLANNING VISIT

The initial/annual visit has components that are the same for all clients regardless of method desired. These are history, lab work, physical exam and intervention to promote wellness or manage problems. In some instances, the client may only desire education and counseling. Use the lists below as a guide and expand as necessary to individualize care, utilizing resources on a priority basis. Appendix A gives in-depth information about the items below.

ASSESSMENT

History:

1. Gynecologic
2. Sexual
3. Obstetrical
4. Contraceptive
5. Assess status of Rubella immunization
6. Assess Sickle Cell Status
7. Medical/Surgical
8. Nutritional
9. Social/Economic
10. Emotional and Client Concerns
11. Literacy, Language Level
12. Other areas as required

Laboratory:

1. Hematocrit and/or hemoglobin
2. Serologic test for syphilis
3. Urinalysis for albumin and glucose
4. Cervical cytology (if not documented normal in the last six months)
5. Gonorrhea culture
6. Other lab as indicated and available:
   - Blood glucose screen
   - Chlamydia screen
   - Complete blood count
   - Hepatitis B screen
   - Herpes culture
   - HIV Antibody screen
   - Pregnancy test
   - Serum Cholesterol/HDL
   - Sickle Cell screen by client request if status unknown
   - TB skin test
   - Urine leukocytes, nitrites or ketones
   - Urine miniculture
   - Vaginal smears/wet preps

THE INITIAL/ANNUAL FAMILY PLANNING VISIT (continued)

PHYSICAL EXAM:

1. Physical measurements-weight, height, blood pressure - see Public Health Nurse (PHN) Manual for method.

2. Nurses with extended role training and certification or a physician should perform:

   a. Complete adult exam

   b. Aspects of reproduction: breasts, pelvic exam, male exam, and

   c. Investigation of problems identified

INTERVENTION:

1. Provide appropriate education regarding:

   a. range of available services
   b. clinic procedures and schedules
   C. value of fertility regulation in maintaining individual and family health
   d. basic reproductive anatomy and physiology
   e. family involvement
   f. self breast exam for females, self testicular exam for males
   g. general information about all methods
   h. when, how and where to seek medical attention
   i. avoiding communicable diseases
   j. STD and HIV risk factors, testing
   k. MMR/Td

2. Provide individualized counseling regarding:

   a. results and implications of the findings of history, laboratory tests, and physical exam
   b. discussion of chosen method
   c. care plan for any problems identified

3. Determine eligibility for WIC if six months or less postpartum (one year or less postpartum, if lactating).

4. Review informed consent for method and ask client to sign the document. Consents are updated yearly.

5. Issue supplies needed for chosen method.

6. Make indicated referrals - coordinate appointments to minimize transportation needs.

7. Provide preconceptual counseling if indicated.

   a. Potential risk of excessive Vitamin A in preconceptual period and early pregnancy

   b. Folic Acid Supplements used prior to pregnancy and in the early part of pregnancy decreases the incidence of neural tube defects.

   c. Medical Conditions (such as diabetes, epilepsy, high blood pressure, heart or kidney disease, infections, hepatitis or anemia) need to be treated before pregnancy.

   d. Drugs and Medicines

   e. Alcohol

   f. Immunizations

   g. **STD**

   h. Smoking

8. Plan return visits/follow-up for problems.

9. Address any further client and family concerns.

10. Document findings, actions, and client response according to PHN manual.

11. With written client permission, request any medical records needed from other providers.

QUICKSTART VISIT

Provision of Oral Contraceptives or Depo Provera with Delayed Clinician Assessment

At times a clinician is not readily available for the initial family planning examination. After performing a nursing assessment and initial lab work, the PHN may provide reproductive health education, and method counseling. After obtaining consent, the PHN may provide the client with up to 3 cycles of a low dose combined oral contraceptive pill or Depo Provera if on day 1-5 of menses . Refer to Public Health Nurse Manual, Standing Orders. The PHN will follow these steps:

- Complete forms 709 and 710 of the family planning record (label physical exam section "deferred").
- Rule out pregnancy by sexual/contraceptive history, menstrual history, and urine pregnancy test.
- Rule out signs/symptoms of STDs. Refer to MSDH STD Manual for PHN assessment if indicated by history.
- Document that the client is non-smoker aged 45* and younger, and has no absolute or relative contraindications to oral contraceptive pill use, if desires oral contraceptive pills. If client desires Depo Provera, document that client has no contraindications for Depo Provera use. (See Family Planning Methods Section, Oral Contraceptives, Combined Pills; Depo Provera)

  * if smoker, age 35 or younger

- Provide counseling regarding contraceptive choices, STD protection, and the need for a physical examination.
- Obtain routine initial family planning lab work.
- Obtain informed consent for oral contraceptive use, or Depo Provera.
- May provide up to 3 cycles of a low dose combined pill. Examples include: Ortho-Cyclen or Ortho Tri-Cyclen, Triphasil.
- May give Depo Provera 150 mg IM if client is on day 1-5 of menses.
- Appointment for clinician visit scheduled as soon as possible for completion of the family planning initial examination.

The 3 month delay of the physical exam may not be extended further, or repeated within a year. Any medical problems associated with the delay of the physical exam must be documented in the client's record.

CONTRACEPTION METHOD FOLLOW-UP/RESUPPLY VISIT

All first time users of a prescription method (pills, IUD, diaphragm) should return 1-3 months after beginning use **of** the method. Revisit schedules during the year should be based on individual user's need for education, counseling, and/or medical care. Certain clients would benefit greatly from a telephone call 1-2 weeks after starting a new method. Such clients are:

- teens aged **17** or younger.
- women who have delivered within the last 18 months.
- clients with medical problems requiring monitoring or ongoing intervention including history of abnormal Pap smears.
- clients that team members believe will have compliance problems.

ASSESSMENT:

History: Review any findings and update any changes. History centers on method used:

1. Problems using method
2. Danger signs and symptoms
3. Discharge/burning/odor
4. Menstrual problems
5. Health habits such as douching

Laboratory:

None scheduled, perform any ordered/indicated for problem management.

Review lab work performed at previous visits.

PHYSICAL EXAM:

1. Physical measurements - weight, (required for pill/Depo Provera users, other method users as indicated), blood pressure for all clients
2. Method specific exam by clinician if indicated and investigation of problems identified in history.

INTERVENTION:

1. Individualized counseling as indicated by client concerns and assessment. Reinforce chosen method's proper use, remind client about danger signs/symptoms and how to seek medical attention. Discuss STD prevention.

2. Issue supplies for chosen method.

3. Make indicated referrals.

4. Plan return visits/follow-up for any problem.

5. Address any further client and family concerns.

6. Document findings, actions, and client response according to the documentation guidelines in the PHN manual.

FAMILY PLANNING PROBLEM VISIT

A client may require a medical follow-up visit for a problem identified at an earlier visit. In another instance, a client may contact the clinic for assistance with a new problem.

A client presenting with a problem should be seen by a nurse who will assess the problem and make a decision as to whether he/she should be seen by a staff clinician or referred to a private physician. Clients telephoning with a concern should speak with a nurse who will assess the need for a visit.

ASSESSMENT:

History: Symptom analysis of the problem and review of systems to detect related signs and symptoms.

PHYSICAL EXAM: Blood pressure on all clients with pulse/respirations, other parameters as indicated.

Laboratory:

As ordered by clinician or defined in Program Standards of Care.

INTERVENTION:

1. Individualized counseling as indicated by client concerns and assessment. Discuss danger signs/symptoms of problem and when to seek medical attention. Discuss STD prevention.

2. Discuss care plan for problem. Demonstrate/explain the use and common side effects of medications. Advise client to take all of medication as prescribed.

3. Plan for follow-up care. Client may need to refer partner(s) for treatment.

4. Make indicated referrals.

5. Address any further client and family concerns.

6. Document findings, actions, and client response according to guidelines in the PHN manual.

7. When oral contraceptives are changed based on clinician assessment, the client should not be charged for resupply if she has paid previously.

PREGNANCY TEST VISIT

Pregnancy testing is only a part of a diagnosis of pregnancy. A positive pregnancy test is considered a presumptive sign of pregnancy rather than a diagnosis of pregnancy. Subjective symptoms such as breast tenderness, nausea, fatigue and urinary frequency are indicative of pregnancy in addition to an overdue or late menstrual period and are the most common presenting history. A physical exam including a pelvic exam provides objective findings to confirm negative or positive pregnancy test results.

Counseling is an essential component of pregnancy testing. It is recommended that, prior to discussing the results of the pregnancy test, the nurse find out what the woman hopes the results of her test will be. This visit provides the client with the opportunity to express and clarify feelings. This information will then assist the nurse in providing the results of the test in a sensitive manner more appropriate to the hopes that the woman has expressed.

The urine pregnancy test is routinely available in the county health departments and has proven to be an accurate method of screening for pregnancy. Do not overstock the kits as the shelf life is comparatively short. The serum pregnancy test is available through the Public Health Lab if indicated. It is not recommended to perform both the urine and serum test, as this is needless duplication. First morning urine is preferred; and the test should **not** be performed before the first missed period.

Pregnancy test will be performed at No charge if

a. Medically indicated
b. Ordered by clinician
c. Client age **20** or less

Negat ve or Nonreactive Pregnancy Test Results:

1. Explore why a pregnancy was suspected, particularly contraception failure.

2. If contraception is desired, offer family planning. Supply with spermicide/condoms and instructions for use until Family Planning appointment. May consider QuickStart if client meets criteria.

3. If a pregnancy is desired, offer pre-conceptual family planning counseling. Explain that family planning services are to help to attain optimal reproductive health and fertility awareness. Folic Acid Supplements used prior to pregnancy decreases the incidence of neural tube defects.

4. Repeat test if no menses in **2-4** weeks. If test remains negative, appoint for a physical exam and medical management of amenorrhea.

Positive or Reactive Pregnancy Test Results:

If client desires, review **all** options including keeping the baby, foster care, adoption, and abortion.

1. Stress importance of prenatal care.

2. **If** client desires prenatal care through the Health Department, offer maternity appointment, WIC, PHRM as appropriate. Refer to the Maternity Manual.

3. If the client informs you that she will not continue the pregnancy, offer family planning appointment for follow-up care.

Documentation:

Minimum documentation of the pregnancy test visit includes:

- Date of visit
- Last menstrual period (number of days, amount, cycle length)
- Was pregnancy desired?
- Contraceptive use since LMP
- Signs and symptoms of pregnancy
- Pregnancy test result
- Recommendation of condom use for disease prevention
- If test is positive, teaching about danger signs and symptoms in early pregnancy, and health promotion for early pregnancy
- Family planning or maternity appointment or statement that client declined care.

FAMILY PLANNING TRANSITION CLIENT

Any family planning client who has been a contraceptor with the family planning program is eligible for transition to another provider if she:

- is no longer child bearing due to menopause, or
- has had surgical intervention (bilateral tubal ligation or hysterectomy), or
- is using no method of contraception, and is **NOT** attempting to get pregnant.

Eligibility for family planning services ends with any medical care provided by a non health department provider to a client without a serious health problem or by completion of a referral for medical care for the client with a serious medical problem.

GUIDELINES FOR DISCHARGE

1. Educate client to the importance of Pap smears, mammograms and other appropriate preventive measures i.e., adult immunizations, osteoporosis, exercise, diet/weight control, smoking cessation, etc.

2. Identify any occurring and ongoing problems needing attention; counsel patient regarding the problems, and complete appropriate referral.

3. Counsel individual on identified high risk behaviors.

4. For clients with serious problems who are transitioning to a non health department provider, provide follow-up to twelve (12) months, if needed, to assist with access to care, if needed.

5. For those "Transition" patients who have an abnormal Pap smear (atypia or dysplasia):

   a. A patient with ASCUS or LSIL in any combination or sequence are eligible for immediate transition. Follow-up concerning the need for repeat Pap or Colposcopy and Biopsy should be discussed with the patient, and copies of Pap smears and other records made available to her physician of choice. The referral of care should be documented in the patient's record. The Pap Log may be cleared under Status Code #12, Consultation/Complete and list date of referral to private M.D.

   b. **Those** patients with **HSIL** are eligible for Colposcopy and Biopsy, Cryo and a **6** month follow-up Pap smear utilizing the application process through the Bureau of Women's Health. Funding for LEEP and Conization is not

available. At the ***6*** month Pap smear, patient is eligible for Transition. Records and pathology results should be made available to her private physician for appropriate follow-up. The referral of care should be documented in the patient's record. The Pap Log may be cleared under **Status** Code #12, Consultation/Complete and **list** date of referral to private M.D.

C. For HSIL patients in those districts where the Breast and Cervical Cancer Program (BCCP) is available, billing for Colposcopy and Biopsy on non-family planning patients can be made through the BCCP. Cryo, LEEP, and Conization are not covered services for funding under the BCCP. These patients will be transitioned to their private physician after the ***6*** month Pap smear, unless otherwise eligible for the BCCP.